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No. 07-1328

OFFICE OF THE
SUPREME CO

In The
Supreme Court of the United States

ROSA ACUNA,

Petitioner,

v.

SHELDON C. TURKISH, M.D., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The Supreme Court Of New Jersey

BRIEF OF SANDRA CANO, THE FORMER "MARY DOE" OF DOE V. BOLTON; WOMEN INJURED BY ABORTION; AND, AMERICAN ASSOCIATION OF PRO-LIFE OBSTETRICIANS AND GYNECOLOGISTS (AAPLOG) AS AMICI CURIAE IN SUPPORT OF PETITIONER

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STATEMENT OF INTEREST OF THE AMICI CURIAE

Consent to file this amici curiae brief was given by both parties. This brief supporting Petitioner was prepared by counsel for Amici.[1]

This case is of great national importance and consequence because the issue faced by Rosa Acuna is the principal issue facing approximately one million women each year in the United States who need and are entitled to full, accurate, and truthful information to exercise their constitutional right to decide whether to abort their unborn child. Due to the well-established physical and psychological risks and consequences for women, this decision has far-reaching and long-lasting implications.

The heart of this case relies on cases previously decided by this Court in *Roe v. Wade, Doe v. Bolton,* and *Planned Parenthood v. Casey* in which this Court justifiably expected that there would be a normal doctor-patient relationship and that a woman would

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[1] The parties were notified ten days prior to the due date of this brief of the intention to file. The parties have consented to the filing of this brief. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Trinity Legal Center is a nonprofit corporation and is supported through private contributions of donors who have made the preparation and submission of this brief possible. No person other than amici curiae, their counsel, or donors to Trinity Legal Center made a monetary contribution to its preparation or submission.

receive truthful and non-misleading information. A woman expects to get full, accurate, and truthful information from her doctor. Failure to give such information prevents her from making an informed and knowing exercise of her constitutional right to decide whether to abort her unborn child.

Many women who have an abortion suffer from both physical and psychological harm. Failure to properly inform a woman with full, accurate, and truthful information puts the woman at even greater risk of psychological harm when she learns the truth. This case exemplifies the problem.

Amici Sandra Cano is the "Doe" of *Doe v. Bolton*. It was *Doe v. Bolton* which provided for the health exception that led to abortion on demand and partial birth abortion; however, Sandra never wanted an abortion. She only sought legal help to get a divorce and regain custody of her two oldest children. *See* Appendix A. Years later when she realized that her name and life were used to bring abortion on demand and partial birth abortion, she suffered from the devastation of being misled as to the true nature of her case, which was in direct contradiction to her intent, requests, and beliefs. In addition, she has suffered the devastation of knowing that it was her case that has been responsible for approximately 45 million abortions. Thus, she too understands the psychological trauma that post-abortive women suffer when they learn the truth that abortion killed their unborn child and experience the negative physical and psychological consequences of abortion.

Other Amici are post-abortive women who have suffered and attest to the fact that adverse physical and psychological effects of abortion have negatively affected their lives. They regret the fact that they were never given full, accurate, and truthful information concerning the nature and risks of abortion. All of the women have used their full name in the original Affidavits on file at the office of Trinity Legal Center, but some have requested that only their initials be used publicly to protect their privacy and confidentiality.

Amici American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) was founded in 1973 as a recognized group within the American College of Obstetricians and Gynecologists (ACOG). AAPLOG has approximately 2100 members, mostly ob-gyn physicians from across the United States. These physicians understand the importance and value of pregnant women having full, accurate, and truthful information to make an informed decision. AAPLOG believes that it is the responsibility and duty of the physician to properly advise and inform his/her patient. They have experience with patients who were not fully informed and who experienced adverse physical and psychological effects of abortion. Members of AAPLOG have served as expert witnesses on the abortion issue in the courts and before legislative bodies.

Because abortion was generally not legal or widespread prior to the decisions in *Roe v. Wade* and *Doe v. Bolton*, this Court made non-evidence based

assumptions concerning abortion. Now, thirty-five years later, post-abortive women Amici provide this Court with their real life experiences and attest that abortion in practice hurts women's psychological health which is confirmed by medical research. *See* Appendix B. The post-abortive women Amici are:

Tina Brock (Georgia)
Kay Lyn Carlson (Kansas)
Cynthia Carney (Oklahoma)
T. C. (North Carolina)
Karen R. Hartman (Arizona)
Sherri Hayden (Texas)
Tammy Holly (Michigan)
Dawn Jackson (Texas)
Alveda King (niece of Dr. Martin Luther King, Jr.) (Georgia)
Kay Painter (Idaho)
Rebecca Porter (Florida)
Kathy Rutledge (Kentucky)
Caron Strong (California)
Norma Tanton (Texas)
Julie Thomas (Georgia)
Cynthia Ann Williamson (Florida)
Ann M. Younger (Texas)
Joyce Leslie Zounis (Colorado)

SUMMARY OF THE ARGUMENT

I

The issue in this case is whether the state interfered with a woman's constitutional right to decide to abort her unborn child by explicitly or implicitly endorsing the physician's medically false information

about the status of her unborn child. While this Court held that a woman has a right to decide whether to have an abortion, it also expected, as with any medical treatment, that a woman would be given truthful and non-misleading information by her physician. When a woman is given false or misleading information, it impacts on her decision regarding whether to exercise her constitutional right to decide and potentially causes greater psychological harm when she learns the truth. Therefore, this Court should require that a physician give a woman full, accurate, and truthful information to make an informed decision.

II

Rosa Acuna's case is not an isolated incident. State legislatures have determined that women have a right to know certain information about the physical and psychological risks of abortion. In addition, legislative findings demonstrate that women are not given this information prior to an abortion. Medical research confirms what Rosa Acuna and other post-abortive women have experienced that abortion places women at an increased risk for depression, suicidal ideation, suicide, anxiety, and substance abuse. Lack of pre-abortion counseling and informed consent are key factors in post-abortion difficulties. Furthermore, avoiding a discussion of fetal development by describing a fetus in terms of "blood" or "tissue" is not truthful and can lead to devastating psychological consequences when a woman obtains truthful information. Because the absence of truthful

information increases the risk of psychological problems, this Court should require that a physician provide truthful and non-misleading information, and therefore, this Court should grant the Petition for Writ of Certiorari to ensure that pregnant women are given full, accurate, and truthful information before they exercise their constitutional right to decide.

ARGUMENT

I. THIS CASE IS CERTWORTHY BECAUSE THE NEW JERSEY SUPREME COURT MISINTERPRETED *ROE V. WADE* AND ITS PROGENY AND ONLY THIS COURT CAN CORRECT THE ERROR.

A. The New Jersey Supreme Court Erred Because the State Should Not Endorse a Physician Giving Medically False Information about the Status of a Woman's Unborn Child as It Interferes with Her Constitutional Right to Decide Whether to Abort the Child.

Because this Court constitutionalized the abortion issue in *Roe v. Wade*[2] and *Doe v. Bolton*,[3] only this Court can correct the lower court's errors in interpretation and application. The New Jersey Supreme

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[2] 410 U.S. 113 (1973).

[3] 410 U.S. 179 (1973).

Court, relying on *Roe v. Wade*, allowed the physician to give Rosa Acuna false information.[4]

When Rosa Acuna specifically asked her physician if her eight-week-old unborn child was a baby, he said "Don't be stupid, it's only blood."[5] It cannot be disputed that this information – that her eight-week-old unborn child was merely "blood" – was clearly false.[6] After being taken to the emergency room because of massive hemorrhaging, she was told that because of an incomplete abortion parts of the baby were left inside her.[7] Upon doing research, she learned the truth about the gestational development of her baby which led to psychological problems and a diagnosis of post-traumatic stress syndrome.[8]

The question posed in this case is whether the state interfered with a woman's constitutional right to decide to abort her child, by explicitly or implicitly

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[4] *See* Acuna v. Turkish, 192 N.J. 399, 930 A.2d 416, 426 (2007).

[5] *Id.* at 419.

[6] For example, the Texas "Woman's Right to Know" booklet describes an eight-week-old unborn child as having all essential organs beginning to form; elbows and toes are visible; the fingers have grown to the first joint; facial features – the eyes, nose, lips, and tongue – continue to develop; the outer ears begin to take shape; organs begin to be controlled by the brain, and the baby's length is about 1/2 to 3/4 inch. "A Woman's Right to Know" by the Texas Department of Health (2003), available at http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf.

[7] Acuna v. Turkish, 192 N.J. 399, 930 A.2d 416, 419 (2007).

[8] *Id.*

endorsing the physician's medically false information about the status of her unborn child.

In *Roe v. Wade*[9] and its progeny,[10] this Court held that a woman has a right to decide whether to have an abortion. Amici believe that *Roe* was incorrectly decided and should be overruled; however, because *Roe* and its progeny are the law, it is clear that Rosa Acuna's constitutional right to decide whether to have an abortion was significantly infringed upon by the state court in rejecting her claims. This Court afforded a woman's right to decide constitutional protection as a part of her substantive liberties as an individual.[11] A woman's right to make this decision in a fully-informed manner is critical because, as this Court recognized, abortion

> is an act fraught with consequences for others; for the woman who must live with the implications of her decision; for the persons who perform and assist in the procedure; for the spouse, family, and society which must confront the knowledge that these procedures exist, procedures some deem nothing short of an act of violence against innocent human life; and depending on one's beliefs, for the life or potential life that is aborted.[12]

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[9] 410 U.S. 113 (1973).

[10] Planned Parenthood v. Casey, 505 U.S. 833 (1992).

[11] *Id.* at 852-53.

[12] *Id.* at 852.

Living with the consequences and implications of that decision is exactly what Rosa Acuna suffered as well as the post-abortive Amici and other post-abortive women who suffer from the psychological consequences of abortion.[13] This Court also recognized that women can suffer from depression, regret, guilt, and a loss of self-esteem following an abortion.[14]

The assumption in *Roe v. Wade* and its progeny is that a woman's decision to have an abortion would be made after consulting with her physician.[15] The assumption presumes that the advice and counsel of the physician will be based on sound medical advice concerning the gestational age of the unborn child, the health risks associated with an abortion, and the nature of the medical procedure.[16] This Court expected that the physician would give "truthful, non-misleading information."[17] Rosa Acuna was given **false** information about the characteristics and development of her eight-week-old unborn child. Furthermore, if it were just "blood," she would not expect the risk of being rushed to the emergency room

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[13] Dr. Coleman discusses the psychological problems post-abortive women can have including depression, thoughts of suicide, anxiety, feelings of regret, shame, guilt, bereavement/loss, and lowered self-esteem. *See* Affidavit of Dr. Priscilla Coleman, Appendix B.

[14] Gonzales v. Carhart, ___ U.S. ___, 127 S. Ct. 1610, 1634 (2007).

[15] Roe v. Wade, 410 U.S. 113, 163 (1973).

[16] Planned Parenthood v. Casey, 505 U.S. 833, 882 (1992).

[17] *Id.*

due to an incomplete abortion with "parts of the baby left in" her. This Court expected that truthful, non-misleading information would be given; now, to protect the right to decide, it should require that women, like Rosa Acuna, are given accurate and truthful information.

Roe v. Wade recognized that at a minimum a pregnancy evidences potential life[18] – something more than simply a collection of cells, blood, tissue, or body fluids. Thirty-five years after *Roe*, through the advancement of medical technology, it is well-recognized that life begins at fertilization.[19] The New Jersey Supreme Court erred in relying on thirty-five-year-old science to justify Rosa Acuna's physician giving her false information.[20]

Roe v. Wade[21] and its progeny[22] also recognized the state's interest in promoting life. The state has an obligation to avoid placing an undue burden on a woman's decision; but, it has an equally compelling obligation to ensure that the information given to a woman comports with sound medical judgment,

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[18] Roe v. Wade, 410 U.S. 113, 163 (1973).

[19] For example, *see* "A Woman's Right to Know" by the Texas Department of Health (2003), available at http://www.dshs.state.tx.us/wrtk/pdf/booklet.pdf.

[20] *See* Acuna v. Turkish, 192 N.J. 399, 930 A.2d 416, 426 (2007).

[21] Roe v. Wade, 410 U.S. 113 (1973).

[22] Planned Parenthood v. Casey, 505 U.S. 833 (1992).

advice, and current medical knowledge to ensure a woman's decision is informed.[23]

False or misleading information impacts a woman's decision on how to exercise her constitutional right to decide. If the state explicitly or implicitly minimizes the dangers and thereby impacts the woman's decision, it is significantly interfering with the woman's decision regarding the life within her. This is certainly true in this case where Rosa Acuna specifically asked if the life within her was a baby because the question was the ultimate factor in her decision-making process. This Court recognized that the impact on the fetus would be "relevant, if not dispositive" for most women.[24]

Furthermore, Rosa Acuna's experience is not an isolated event.[25] Abortionists are not giving women full, accurate, and truthful information as anticipated by *Roe* and *Casey*. For example, in the largest government

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[23] *Id.* at 878 (stating "to promote the State's profound interest in potential life, throughout pregnancy the State may take measures to ensure that the woman's choice is informed...").

[24] *Id.* at 882.

[25] For example, the post-abortive women Amici were asked on the affidavit: When and how did you learn it was a baby? The following are typical examples: Tina Brock (Georgia) – "When I became pregnant with my daughter and had an ultrasound." Cynthia Carney (Oklahoma) – "22 years later someone gave me a pamphlet on the development of a preborn." T.C. (North Carolina) – I realized the truth right after the abortion." Norma Tanton (Texas) – "2 years later when Time Magazine came out with an article and photos of how life began."

study since *Roe*, the South Dakota Task Force concluded that "virtually all of the credible objective evidence" compelled the conclusion that abortions in South Dakota were not informed.[26] The Report stated that the record reflects the following concerning informed consent: (a) The abortion providers fail to disclose the essential nature of the procedure – that it terminates the life of the woman's existing child; (b) When they do discuss the procedure, they provide misleading information in misleading terms; (c) The abortion providers give misleading information about the psychological and physical risks to the mother, and do not disclose the direct injury to the child that leads to its death; (d) The abortion providers assume the women have made their decisions before they reach the facility; and, (e) The abortion providers place the burden upon the mothers to discover material facts on their own.[27]

In summary, the New Jersey Supreme Court erred in its endorsement of a physician providing medically false information which interfered with Rosa Acuna's constitutionally protected right to decide. The answer to the specific question that she asked was crucial to her decision to abort her unborn child. At a minimum, this Court should require that a woman be given full, accurate, and

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[26] Report of the South Dakota Task Force to Study Abortion at 37 (December 2005), available at http://ivotemyvalues.com/pdf/contentmgmt/Task_Force_Report.pdf.

[27] *Id.*

truthful information as it expected in *Casey*. Otherwise, a woman's constitutionally protected right to decide to abort her child is meaningless.

B. This Court Has Established That There Cannot Be a Waiver of a Constitutional Right Without a Full Understanding of That Right, and Therefore, There Was an Infringement of Rosa Acuna's Right to Decide to Abort Her Child.

As with other constitutional rights, a person can waive or invoke the right. In other contexts, however, this Court has recognized that certain constitutional rights are so important, and the concomitant risks so high, that the government must ensure that those rights are exercised or waived only after receiving competent advice, including a warning about potential negative effects. For example, *Miranda*[28] warnings are designed to ensure that a suspect's privilege against self-incrimination is protected. Similarly, there is a range of decisions that the defendant must make in a criminal trial including the assistance of counsel in deciding whether to exercise, for example, the decision to speak to the police, take the stand, waive a jury trial, or plead guilty.[29]

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[28] Miranda v. Arizona, 384 U.S. 436 (1966).

[29] *See, e.g.*, Miranda v. Arizona, 384 U.S. 436 (1966) (rights warnings to insure protections associated with Fifth Amendment

(Continued on following page)

The decision on whether to have an abortion has physical and psychological risks and negative effects for the mother and is an issue of life or death for the unborn child. These factors are certainly as important as to whether to speak to the police, waive a jury trial, or plead guilty.

The same approach should apply in the context of a woman's decision to bear or not bear a child. The role of the physician, who is in the position to give sound medical advice to the woman, is to provide her with accurate medical facts. The New Jersey Supreme Court, however, impermissibly shifted the right from the woman to make an informed decision to the physician's right of conscience. Thus, the court allowed the physician to not disclose accurate and truthful information instead of enforcing the right of a woman to have accurate and truthful information to

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privilege against self-incrimination); Boykin v. Alabama, 395 U.S. 238 (1969) (valid guilty plea requires an intentional relinquishment or abandonment of a known right or privilege); Henderson v. Morgan, 426 U.S. 637 (1976) (guilty plea is not valid unless the defendant knows the nature of the offense to which he or she pleads); Patterson v. Illinois, 487 U.S. 285 (1988) (*Miranda* warnings sufficient to apprise defendant of Sixth Amendment right to counsel before post-indictment interrogation); Godinez v. Moran, 509 U.S. 389 (1993) (judge must be satisfied that defendant's waiver of his constitutional right to assistance of counsel at trial is knowing and voluntary); Marone v. United States, 10 F.3d 65 (2d Cir. 1993) (setting out procedures for trial judges to use in accepting waiver of jury trial in federal courts); *see also* Fed. R. Crim. P. 11 (providing detailed guidelines for judges conducting plea inquiries before accepting a guilty plea from a defendant).

decide whether to abort her unborn child. This Court has **never** recognized the right of any physician in any context to falsify critical, factual information involving the patient's medical procedure.

The New Jersey Supreme Court also tried to justify giving false information by stating that a doctor is not compelled to give the information when he has "a different scientific, moral, or philosophical viewpoint."[30] Even assuming arguendo that the physician's moral or philosophical viewpoint was different from current medical science, he could have provided known medical facts, such as the physical characteristics of an eight-week-old unborn child. In other words, he would not have to violate his beliefs while still providing her with medically sound information. She could then decide for herself if the human life within her is in fact a "baby."

The New Jersey Supreme Court in this case ignored these fundamental principles and relied on this Court's decision in *Roe* to justify the doctor's advice that the child growing within the woman was only "blood" – a grossly misleading characterization which reduced the woman's decision to nothing more significant than giving a blood sample or losing blood. Therefore, the New Jersey Supreme Court erred.

As Justice Ginsburg wrote, "The Court is surely correct that, for most women, abortion is a painfully

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[30] Acuna v. Turkish, 192 N.J. 399, 930 A.2d 416, 428 (2007).

difficult decision."[31] At this most difficult time in a woman's life, she should have full, accurate, and truthful information before exercising her constitutional right to decide whether to abort her unborn child.

II. FAILURE TO PROPERLY INFORM A WOMAN PUTS HER AT RISK OF GREATER PSYCHOLOGICAL HARM, AND THEREFORE, THIS COURT SHOULD REQUIRE THAT ACCURATE AND TRUTHFUL INFORMATION BE GIVEN TO A WOMAN SO THAT SHE CAN MAKE AN INTELLIGENT AND KNOWING DECISION CONCERNING HER CONSTITUTIONAL RIGHTS.

A. Recent State Legislative Findings Demonstrate That There Is Serious Physical, Emotional, and Psychological Harm to Women Who Have an Abortion, and Therefore, Women Should Be Fully Informed.

As this Court recognized, "whether to have an abortion requires a difficult and painful moral decision" and is "fraught with emotional consequence."[32]

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[31] Gonzales v. Carhart, ___ U.S. ___, 127 S. Ct. 1610, 1648 n.7 (2007) (Ginsburg, J., dissenting).

[32] Gonzales v. Carhart, ___ U.S. ___, 127 S. Ct. 1610, 1634 (2007).

This Court also noted that "severe depression and loss of esteem can follow" an abortion.[33]

Prior to *Roe v. Wade*[34] and *Doe v. Bolton*,[35] health issues like abortion were decided by the states[36] where hearings could be held to determine whether the medical and scientific knowledge are more advanced to warrant a different legal conclusion. In the thirty-five years since *Roe* and *Doe*, legislatures have determined that there are physical and psychological health risks from abortion and that women should be provided with this information prior to an abortion.

For example, the Texas Legislature passed the "Women's Right to Know" Act[37] in 2003. As a result, the medical board of the Texas Department of Health held hearings and ultimately produced a booklet entitled "A Woman's Right to Know" which is to be distributed to women who are considering an abortion.[38] The booklet provides information concerning

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[33] *Id.*

[34] 410 U.S. 113 (1973).

[35] 410 U.S. 179 (1973).

[36] Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 204 (1824) recognized that under what was later called the state's "police power" the states could regulate "health laws of every description."

[37] Women's Right to Know Act, TEX. HEALTH & SAFETY CODE § 171.001 et seq. (2003).

[38] The booklet is available through the Texas Department of Health or on its website at www.dshs.state.tx.us/wrtp/pdf/booklet.pdf.

the baby's unique DNA,[39] calls the baby an "unborn child,"[40] shows the growth and development from four to thirty-eight weeks gestation,[41] describes the abortion procedure,[42] and explains the physical, emotional, and psychological risks to women.[43]

The Texas Department of Health's booklet warns of the "emotional side of an abortion."[44] It states:

> Some women may feel guilty, sad, or empty, while others may feel relief that the procedure is over. Some women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks, and substance abuse. These emotions may appear immediately after an abortion, or gradually over a longer period of time. These feelings may recur or be felt stronger at the time of another abortion, or a normal birth, or on the anniversary of the abortion.[45]

Currently, a number of state legislatures are considering removing or in some other way limiting

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[39] "Women's Right to Know" booklet at 2.

[40] *Id.*

[41] *Id.* at 3-8.

[42] *Id.* at 14-15.

[43] *Id.* at 15-17.

[44] *Id.* at 16.

[45] *Id.*

the health exception.[46] A notable example is South Dakota which has made substantial and detailed findings after extensive hearings that led to a ban on abortion except to save the life of the mother.[47]

After hearing all of the evidence from experts and post-abortive women, the Task Force stated:

> Further, the Task Force finds that the pre-abortion counseling provided often does not prepare women who have abortions for the psychological outcomes they may experience after their abortions. In addition, women who receive little or no information about possible emotional health risks of this procedure may significantly compromise their mental health and the quality of their lives for years to come. Due to the very limited information disclosed by abortion providers, women are not fully aware that abortion carries with it the potential to damage their physical, emotional, interpersonal, and spiritual well-being.[48]

The Task Force also addressed the issue of the psychological consequences of terminating the life of the child. The Task Force stated:

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[46] For example, Alabama, Indiana, Georgia, Kentucky, Louisiana, Missouri, Michigan, Mississippi, Ohio, Oklahoma, Tennessee, and West Virginia.

[47] Report of the South Dakota Task Force to Study Abortion (December 2005), available at http://ivotemyvalues.com/pdf/contentmgmt/Task_Force_Report.pdf.

[48] *Id.* at 47.

> Perhaps worse, the pregnant mother is not told prior to her abortion that the procedure will terminate the life of a human being. The psychological consequences can be devastating when that woman learns, subsequent to the abortion, that this information was withheld – information that would have resulted in her declining to submit to an abortion. Her anger at being deceived and being prevented from making an informed decision for herself is exacerbated by her realization that she was implicated in the killing of her own child in utero. Aside from the injustice of her being deprived of making her own informed decision (see Section II-D), the psychological harm of knowing she killed her child is often devastating.[49]

In addition, the Task Force found that:

> ...it is simply unrealistic to expect that a pregnant mother is capable of being involved in the termination of the life of her own child without risk of suffering significant psychological trauma and distress. To do so is beyond the normal, natural, and healthy capability of a woman whose natural instincts are to protect and nurture her child.[50]

The Task Force heard testimony from Dr. Vincent Rue, Ph.D., who is a psychotherapist and a professor, and was special consultant to then-U.S. Surgeon

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[49] *Id.*

[50] *Id.* at 47-48.

General Dr. C. Everett Koop on abortion morbidity. Dr. Rue provided the first clinical evidence of post-abortion trauma in 1981 and identified this psychological condition as 'Post-Abortion Syndrome' in testimony before the U.S. Congress."[51] The Task Force heard evidence that individuals with Post-Abortion Syndrome "experience symptoms of avoidance (efforts to escape from reminders of the event), intrusion (unwanted thoughts, nightmares, and flashbacks related to the event), and arousal (exaggerated startle reflex, sleep disturbance, irritability) for a month or more following exposure to a traumatic event."[52] Although for some women, the initial response is one of relief, many women later avoid the problem through repression and denial, usually for years – "5 years is common, 10 or 20 is not unusual."[53]

Abortion hurts women emotionally and psychologically, and therefore, this Court should grant the Petition for Writ of Certiorari to ensure that women are entitled to full, accurate, and truthful information before they exercise their constitutional right to decide.

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[51] *Id.* at 53.

[52] *Id.* at 44.

[53] Willke & Willke, ABORTION 50 (Hayes Pub. Co. 2003).

B. The Real Life Experiences of Post-Abortive Women and Scientifically Validated Research Demonstrate That Abortion Hurts Women Physically and Psychologically, and Therefore, This Court Should Require That Full and Accurate Information Be Given to a Woman Prior to Exercising Her Right to Decide.

The Court of Appeals for the Fifth Circuit recently cited testimony that abortion as practiced is "almost always a negative experience for the patient..."[54] The post-abortive women Amici's real life experiences attest that there are harmful and negative physical and psychological consequences to abortion.[55]

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[54] Women's Medical Center v. Bell, 248 F.3d 411, 418 (5th Cir. 2001).

[55] For example, post-abortive women Amici attest: Tina Brock (Georgia) – "I suffered from severe depression for years after my abortion until I found healing." Cynthia Carney (Oklahoma) – "I had a replacement child. But after I gave birth to him, I couldn't shake the depression or the feeling that something was wrong. The relationship with my 1 year old changed, I felt detached from him & didn't know why – there was an aching hole in my heart." T.C. (North Carolina) – "I regret it more than anything else in my difficult life;" Karen Hartman (Arizona) – "I hated myself and told myself that daily. 'I hate myself, I hate myself!" I cried on my horses necks each morning. I would try to escape the pain by riding the horses, working hard, trying to please others. I wore a plastic smile, inside I was a hole of despair. I wanted out, but I had not the tools to climb from this deep dark hole. My nightmares involved trying to pull a baby out of a hole, never succeeding." Sherri

(Continued on following page)

One of the largest pregnancy resource centers, Care Net[56] and other pregnancy resource centers attest that their organizations had over 100,000 women in post-abortion recovery programs in 2004 alone. It is estimated that there are more than one million abortions each year. If even 1 in 10 women suffer from negative psychological consequences of abortion, then this Court should require that women are given full and accurate information to make an informed decision.

Medical research confirms what Rosa Acuna and other post-abortive women have experienced. Dr. Priscilla Coleman attests after approximately eighteen years

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Hayden (Texas) – "...depression, loss of joy, I isolated myself, fearful, loss of peace, emotionally numb." Kathy Rutledge (Kentucky) – "My abortion placed a dark cloud over my life that never lifted – I was never the same. It was as if two people died that day – my baby died physically, and I died emotionally and spiritually. I continued to manage my life mentally, but in a fog, devoid of the enormous amount of creativity and energy I had displayed in high school. Looking back, it was an unfortunate waste of two lives." Norma Tanton (Texas) – "It has left a hole in my soul – I have had to work through depression, guilt, shame, condemnation & suicidal thoughts thru post abortion counseling. 24 years after my abortion, I never knew that was available until 2 years ago – I tried to commit suicide once – I felt unworthy of being a mother to my step daughter – I had a lot of suppressed anger over the situation and disassociated myself from people distrusting them. Learn to live w/a mask – full of fear & anxiety of others finding out."

[56] Care Net was founded in 1975. Its focus is to develop, equip, and promote more than 900 pregnancy centers across North America. *See* www.care-net.org.

of extensive research that women are at an increased risk for depression, suicidal ideation, suicide, and death.[57] In addition, other well-established psychological difficulties include anxiety, substance abuse, unrelenting feelings of regret, shame, guilt, bereavement/loss, and lowered self-esteem.[58]

Dr. David Reardon, one of the world's leading experts on the effects of abortion on women, further demonstrates the devastating psychological consequences of abortion. Dr. Reardon states that following temporary feelings of relief, there is emotional "paralysis" or post-abortion "numbness," guilt and remorse, nervous disorders, sleep disturbances, sexual dysfunction, depression, loss of self-esteem, self-destructive behavior such as suicide, thoughts of suicide, and alcohol and drug abuse, chronic problems with relationships, dramatic personality changes, anxiety attacks, difficulty grieving, increased tendency toward violence, chronic crying, difficulty concentrating, flashbacks, and difficulty in bonding with later children.[59]

As Dr. Coleman attests, pre-abortion counseling and informed consent are key factors in post-abortion

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[57] Affidavit of Dr. Priscilla Coleman, Appendix B.

[58] *Id.*

[59] "The Aftereffects of Abortion," www.afterabortion.info/complic.html (calling abortion a public health issue and listing the physical and psychological effects of abortion).

difficulties.[60] Avoiding discussion of fetal development or using terms like "tissue" or "blood" encourages consent based on false and misleading information, but a woman may not give consent if she is told the truth.[61] Furthermore, when a woman obtains truthful information concerning fetal development, devastating psychological consequence are more probable.[62]

Although it is frequently overlooked, a critical factor in a woman's decision-making process is that abortion is legal.[63] Therefore, most women assume

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[60] Affidavit of Dr. Priscilla Coleman, Appendix B.

[61] *Id.*

[62] *Id.*

[63] For example, post-abortive women Amici attest: Tina Brock (Georgia) – "I felt if it was legal it must be OK. Since I was lied to and told it was just a blob, I didn't know it was murdering a human being & at 9 weeks it is very much a human being therefore it was murder & murder is not legal – well except abortion." Cynthia Carney (Oklahoma) – "I would have never had an abortion if it was illegal. Simply went into an office that was offering free pregnancy tests, and when I left they told me it was just tissue. No one had ever said that to me before." Karen Hartman (Arizona) – "We would not have considered an abortion had it been illegal. I thought 'It's legal, it must be okay, my government couldn't hurt me!'" Sherri Hayden (Texas) – "It made it too easy and accessible." Kay Painter (Idaho) – "Never would have considered abortion had it been illegal. Laws are to protect you. If it's legal it must be a good choice and safe." Kathy Rutledge (Kentucky) – "My mother didn't give me any options and threatened that my Dad (my parents were divorced) would kill her if he found out I was pregnant. I believed her, and since abortion was legal, it seemed like a legitimate way to resolve the 'family' crisis. Legalized abortion caused undue pressure to terminate my pregnancy without consideration of other options."

(Continued on following page)

that abortion is not fraught with physical and psychological consequences.

This Court recognized that a state requirement that a woman be informed does not create an undue burden. It also expected that a woman would be given truthful and non-misleading information. Amici urge this Court to grant the Petition for Writ of Certiorari to ensure that physicians will provide a woman with truthful and non-misleading information at what has been recognized as the most difficult time in her life.

CONCLUSION

When this Court granted women the constitutional right to decide whether to abort their unborn child, it assumed that each woman would be given accurate and truthful information to make an informed decision. At this most difficult time in a woman's life, the women of this nation need to trust that physicians will provide accurate and truthful information. As this Court recognized, abortion can cause psychological harm such as depression, regret, guilt, and low self-esteem. However, a woman is at greater risk of these complications when she later

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Norma Tanton (Texas) – "If abortion wasn't legal I wouldn't have had an abortion. I was already going through an emotional trauma by being disowned by his parents' when my mother-in-law pressured and talked me into an abortion. She made the appt and took me." Cynthia Williamson (Florida) – "If it wasn't legal I wouldn't have had one. You think laws and legal things are right. Wouldn't be legal if it was going to hurt or kill. The law does not protect women."

learns the truth that her choice to have an abortion was instead the choice to kill her unborn child.

Rosa Acuna directly asked her doctor if her eight-week-old unborn child was a baby. He gave her false information when he said it was just "blood." It was only after suffering physical complications due to an incomplete abortion that she was told parts of her baby had been left inside her. Upon doing research, she learned the truth about the gestational development of her baby. This led to psychological problems and a diagnosis of post traumatic stress syndrome.

The New Jersey Supreme Court erred in condoning the physician giving Rosa Acuna false and misleading information. This Court expected that a physician would give truthful, non-misleading information. Without accurate and truthful information, a woman cannot make an informed decision to exercise her constitutional right to decide whether to have an abortion.

Therefore, Amici urge this Court to grant the Petition for Writ of Certiorari as this important issue affects millions of women who are considering whether to abort their unborn child.

Respectfully submitted,

LINDA BOSTON SCHLUETER
State Bar Card No.: 24000127
Supreme Court Admission: 1976

KATHLEEN CASSIDY GOODMAN
State Bar Card No.: 24000255
Supreme Court Admission: 2001
Counsel for Amici Curiae

APPENDIX A
AFFIDAVIT OF SANDRA CANO

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ATLANTA DIVISION

Sandra Cano, formerly known as MARY DOE,	§	
Plaintiff,	§	
V.	§	
ARTHUR BOLTON, Attorney General of the State of Georgia Through His Official Successor in Office, THURBERT E. BAKER; LEWIS R. SLATON, as District Attorney of Fulton County, Georgia Through His Official Successor in Office, PAUL L. HOWARD, JR.; And HERBERT T. JENKINS, as Chief of Police of the City of Atlanta Through His Official Successor in Office, Richard Pennington,	§	**CIVIL ACTION NO. 13676**
Defendants.	§	

App. 2

AFFIDAVIT OF SANDRA CANO

STATE OF GEORGIA §
§ KNOW ALL MEN BY
COUNTY OF FULTON § THESE PRESENTS:

BEFORE ME, the undersigned authority, on this day personally appeared SANDRA CANO, who after being duly sworn upon his oath deposed and said as follows:

1. My name is Sandra Cano, and I reside in Georgia. I am competent to make this Affidavit. I have personal knowledge of the facts stated herein and the following is true and correct.

2. In 1973, I was the woman designated as 'Mary Doe', the Plaintiff in *Doe v. Bolton*, 410 U.S. 179 (1973), the companion case to *Roe v. Wade*, 410 U.S. 113 (1973). Although the courts understood that 'Mary Doe' was not my real name, what the courts did not know was that, contrary to the facts recited in my 1970 Affidavit, I neither wanted nor sought an abortion. I was nothing but a symbol in *Doe v. Bolton* with my experience and circumstances discounted and misrepresented. During oral arguments before the United States Supreme Court one of the Justices stated that it did not matter whether I was a real or fictitious person. This is where the Court was so very wrong. It did matter. I was a real person, and I did not want an abortion.

3. Abortion is just like *Doe v. Bolton*. It discounts the real experiences of the mothers. It misrepresents that abortion is for them. Just as Mary Does' true desires were hidden from the courts by those promoting abortion, so, too, have the real facts about abortion been hidden. Today, this Court will know the real truth about the real woman who was used to deceive, not only the courts, but the women of this nation about the reality of abortion.

4. 'Sandra Race Bensing' was my real name in 1970. I was twenty-two years old and pregnant with my fourth child when I first met the *Doe v. Bolton* attorney, Margie Pitts Hames. I had gone to legal aid to get a divorce and to find an attorney to help me regain custody of my two children. My husband was not supporting us, and we had to live at the Salvation Army. At times we lived with my mother, but my stepfather did not want us there. I loved my children, but I could not care for them financially.

5. I was a trusting person and did not read the papers placed in front of me by my lawyer. I truly thought Margie Pitts Hames was having me sign divorce papers. I did not even suspect that the papers related to abortion until one afternoon when my mother and my lawyer told me that my suitcase was packed to go to a hospital, and that they had scheduled an abortion for the next day. They advised me that my doctor, Dr. Donald Block, was going to perform an abortion. I told both my mother and my lawyer that I would not

have an abortion. Not then. Not ever. They persisted in their demands upon me.

6. When the demand for an abortion persisted, I fled to Oklahoma and stayed at the home of my ex-husband's grandmother. I remained in Oklahoma until my mother and lawyer assured me that they would cease their pressuring me to have an abortion. I was relieved that the ordeal was ended. Because they promised never to force me to have an abortion, I returned to Georgia.

7. My lawyer sent me a plane ticket so I could fly from Oklahoma to Georgia. She wanted me to be in a courtroom with other pregnant mothers. The night before I went to court, my mother and my lawyer expressed concern that I would leave again, and so they had me stay at the apartment of a legal-aid lawyer. Before the court appearance, I was told by my lawyer not to say anything in court. As a result, I never did say anything in court.

8. My predicament made it difficult for me to take care of my children, but I didn't need an abortion. I needed help, but all of the people around me – my husband, my mother and my lawyer – refused to help me with my children.

9. Instead of real help, my mother, stepfather and my lawyer persisted in their demands that I have an abortion. Those demands were made for themselves so they would not be burdened. It was, in my mind, a demand for what they thought was the easiest way for

them to get out from under any obligation to help my new baby and me. But the abortion was not in my interest. I was the mother of a baby for whom I was responsible. I had a natural desire to have my baby and to raise her. I carried my child to full term and gave birth. Because no one would help me I felt compelled to surrender my rights and give my baby up for adoption.

10. One day in 1973, my mother and stepfather called me into their bedroom. Their television was on. They shouted to me excitedly, "Look! You won! You won!" Margie Pitts Hames was on television and the story reported that the United States Supreme Court had made abortion legal. At that time, I did not fully comprehend what my role was in the Court's decision in *Doe v. Bolton*.

11. Over the years, I gained a greater and greater sense that I was wrongfully used in *Doe v. Bolton*. A number of years ago, I decided that I wanted to see my file in the case so I could see what was said about me. I went to the courthouse to see my records which were under seal. An attorney, Wendell Bird, agreed to represent me and he asked that my records in my case be unsealed. I produced my driver's license, my birth certificate, and my marriage certificate. The attorney who represented me in *Doe v. Bolton*, Margie Pitts Hames, tried to stop me from getting my own records, and I did not understand why.

12. It was only when I first saw the opened records in *Doe v. Bolton* that I understood why Margie didn't want me to see them. The records stated that I applied for an abortion, was turned down, and, as a result, sued the state of Georgia. According to the records, I had applied for an abortion through a panel of nine doctors and nurses at a state-funded hospital, Grady Memorial Hospital. That was a false statement. After reading the court records, I contacted the hospital and tried to obtain my records. At first I was told there were records, but when my new attorney sent his legal assistant to review the records, we were told that they did not exist. The hospital said they didn't have any records. I never sought an abortion there or anywhere else.

13. At times, I have been forced to reflect upon the events that led up to that day in 1973 when my mother and stepfather told me about the Supreme Court decision in *Doe v. Bolton*. In 1970, my life was a mess. I was having my fourth child, but no responsible husband or real place to live. I was uneducated. When I came back from Oklahoma, I was so relieved that no one was going to pressure me to have an abortion that I took part in a court proceeding without understanding what was really happening. I was used wrongly, but I didn't inquire enough. In retrospect, there were big signs which revealed what was happening.

14. Once a television man came to Margie's office and I was asked what I thought of abortion. I told him that, "I don't believe in abortion and I don't want an abortion." I also said I didn't care if anyone else had an abortion, that it wasn't my business. All I cared about, at that time, was that I didn't want an abortion. I was not thinking of the other women. I did not understand that I was involved in a case that sought to legalize abortion. I was naïve. In retrospect, perhaps, I could have discovered what was going on. But I was in a crisis. I depended on my mother's help. My lawyer became upset with me because I would never say to anyone that I would have an abortion. I should have, perhaps, understood what was happening, but I was simply attempting to survive. I remember Margie debating me. She claimed we were involved in a liberation right. She said women were entitled to equal pay for equal work, and I agreed. I never saw the pleading filed in court.

15. Many years later, when I saw the unsealed records in my case, I could not believe what the certification filed in my name said. I am certain the signature on the affidavit that said I wanted an abortion was not mine. I never saw that affidavit until the records were unsealed. If it was my signature, it was obtained without my knowing the contents of the affidavit. I had fled to Oklahoma to avoid an abortion. My lawyer knew I would never say I wanted one. The only reason I went to a lawyer was to get my children back. My

predicament was used to argue that my new baby's life should be terminated.

16. I have often rethought how my involvement in *Doe v. Bolton* came about. Over the years it has haunted me. I never had an abortion, but I know what it is like to feel responsible for one. I know what it is like to feel like a mother who helped terminate the life of her own child. After *Doe v. Bolton* was decided and I was told about my involvement, I felt responsible for the experiences to which the mothers and babies were being subjected. In a way, I felt that I was involved in the abortions – that I was somehow responsible for the lives of the children and the horrible experiences of their mothers. I have felt that experience that the death of a child is my fault; the helplessness the mother feels as events occur around her without any power to stop them; and the guilt that is associated with being told by the courts and society that the child's death was performed for the mother and only the mother.

17. This last assertion – that abortion is performed for the mother – is the cruelest misrepresentation of all. My own circumstance, the one used to justify legal abortion in the first place, is a perfect example of this reality. There are many doctors, and clinics and others who were plaintiffs in *Doe v. Bolton*. As Mary Doe, I was the only pregnant mother who was a plaintiff. All of these other people – the doctors, nurses and clinics were using the Court to do what they thought was

in my interest. They pressured the Court claiming I need the right to terminate the life of my own child. It was their solution, not mine. They claimed they did it out of compassion for me. But it was a false compassion. A true compassion would result in the fathers living up to their responsibilities. A true compassion, once a mother is in the predicament that the child's father abandoned her, would advise her how to get help and would provide her help. Unfortunately, the legal right to an abortion was sought in my case because others thought it was too hard for them to give me real help. The abortion was sought for them, not for me.

18. But no matter how hard life happens to be, no one has the right to kill a baby – especially the baby's mother. She is the trustee of her child's life. She, of all people, has the sacred duty to protect the child. But the child's interests are not at odds with her own. They are in concert with one another. The mother derives a great benefit from her relationship with her child. It is as beneficial to her as it is the child. It is never in the interest of a mother to terminate the life of her own child.

19. I have been forced to live with the consequence of this false compassion for too long for me not to bring to the attention of the Court the fact that abortion is not in a woman's interest, and the fact that legalization of abortion began with manipulations and misrepresentations. Too many women who lost their children through abortion

have told me of their emptiness, their sadness, the void in their lives, and how others forced them to have abortions and then blamed the abortion on the mother.

20. The experience of *Doe v. Bolton* must be understood and accounted for, not simply to correct the record in my own case, but to correct the law of abortion in general: abortion is not in the interest of a mother. It is a false solution imposed upon a mother by others.

21. *Doe v. Bolton* and my circumstanced [sic] were misused. *Doe v. Bolton* was a fraud upon the court. *Doe v. Bolton* was a secret case about abortion, which is a secret procedure. This secretiveness allows others to prevail upon the mother and others can act against her interest. Women have told me how they were forced to have an abortion against their will. If it was alleged that I spoke for other women in *Doe v. Bolton*, then I gladly speak for other women in this case to say that abortion is too coercive by nature; too much the will of others; too much the will of a society which finds abortion more convenient for it than a commitment to the well being of the mother and the child.

22. The real experiences of the women must be known and taken into consideration by the court. Abortion is too much what others would like a woman to do, rather than what is in her interest and what she really wants.

23. Others told the court that I wanted an abortion. The law has developed, in part, based upon what my lawyer claimed I wanted, and that abortion was in my interest. I feel I have the duty to tell this Court the truth about what I really thought then, and what I think now. As the Plaintiff in *Doe v. Bolton*, I have a very substantial interest in the litigation before this court in the matter of *Roe v. Wade* and I can provide the court a unique perspective of the *Doe v. Bolton* case not available from any other source.

24. In the 1970s the people closest to me successfully manipulated my circumstances to justify abortion and wanted me to have an abortion, but I refused. Today this Court has the opportunity to review, not just the real facts surrounding the *Roe v. Wade and Doe v. Bolton,* the original abortion decisions, but the opportunity to review the testimony of hundreds of women who have real, true, experiences with abortion and not perpetuate the *Doe v. Bolton* fraud upon the Court.

Further Affiant sayeth not."

/s/ Sandra Cano
Sandra Cano a.k.a. Mary Doe of
Doe v. Bolton

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 12th day of August, 2003.

/s/ Justin [Illegible]
NOTARY PUBLIC IN AND FOR
THE STATE OF GEORGIA
My commission expires:
Notary Public, Fulton County, Georgia
My Commission Expires Oct. 18, 2005

APPENDIX B

Affidavit of Dr. Priscilla K. Coleman, Ph.D

STATE OF GEORGIA §
§ KNOW ALL MEN BY
§ THESE PRESENTS:
COUNTY OF WOOD §

BEFORE ME, the undersigned authority, on this day personally appeared Priscilla K. Coleman, Ph.D. who is personally known to me, and after being by me first duly sworn according to law on her oath did depose and say that:

1. "My name is PRISCILLA K. COLEMAN. I am over the age of eighteen (18) years of age and I reside in Bowling Green, Ohio. I am fully competent to make this Affidavit. I have personal knowledge of the facts stated herein and the following is true and correct.

2. I am a developmental psychologist and an Associate Professor of Human Development and Family Studies at Bowling Green State University in Ohio. I have written 44 peer-reviewed scientific articles (42 published to date), of which 29 are on the psychology of abortion.

3. The opinions expressed in the Affidavit are based upon my education, professional experience, the psychological research I have conducted, and my extensive and ongoing review of the abortion and mental health literature. The references in Exhibit A and Tables 1-4 in Exhibit B list publications that have been formative in shaping my opinions on the

issues identified in this Affidavit, as well as other publications too numerous to mention in my ongoing review of the scientific literature.

Overview and Synopsis of Opinions

4. Over the course of my professional career, I have spent approximately 18 years conducting research, publishing the results of studies, analyzing the research of others, and performing systematic reviews of the literature for publication in peer-reviewed journals. Based on the research I have done, it is my opinion and I can say with a reasonable degree of scientific and medical certainty that abortion is a substantial contributing factor in women's mental health problems, including depression and increased risk of death from suicide, natural causes and accidental injury.

5. Scientific evidence accrued over the last two decades and published in leading peer-reviewed journals in psychology and medicine indicates that abortion places women at an increased risk for depression, suicidal ideation, suicide, and death in general. Other well-established psychological difficulties associated with abortion include anxiety and substance use disorders. Women undergoing this procedure often report additional adverse consequences including unrelenting feelings of regret, shame, guilt, bereavement/loss, and lowered self-esteem. Many women withdraw from family and friends, become preoccupied with the abortion, and

develop a sense that their lives will never feel right again.

6. Furthermore, pre-abortion counseling and informed consent are key factors in post-abortion difficulties. It is my opinion and research supports that when a woman feels she was misinformed or denied relevant information, this often precipitates post-abortion difficulties.

7 Avoiding discussion of fetal development or using terms like "tissue," "blood," "content of the uterus," or "a clump of cells" to refer to the fetus often encourages consent that would not have been made if she were told the truth. This deceitful practice denies a woman the information a reasonably prudent person would expect in considering whether or not to pursue the abortion. Subsequently, if a woman obtains truthful information concerning fetal development, devastating psychological consequences become more probable.

Suicide Ideation and Suicide

8. Abortion is a significant contributing factor in suicidal ideation and suicide. In Table 1 of Exhibit B, I provide a synopsis of the 6 available studies dealing with abortion and suicidal behavior. When considered in totality, the scientific criteria for isolating a significant risk factor are sufficiently met. Abortion is a consistent and strong risk factor for suicidal behavior. The studies are all large scale, prospective in nature, and they incorporate a variety of different types of

comparison groups as well as additional control techniques, effectively fortifying the level of confidence in the results derived. In a review of the largest and strongest published literature, Thorp and colleagues (2003) arrived at a similar conclusion.

Alcohol and Drug Abuse

9. Alcohol and drugs may be used as convenient means for suppressing or blunting painful memories. There are numerous obvious problems associated with use of substances for coping with a painful abortion experience. Specifically, it is likely to facilitate avoidance and hinder women from coming to terms with the underlying cause of their discomfort. Further, the many physical, psychological, social, and practical problems associated with substance abuse will in all likelihood introduce new sources of stress which can exacerbate the traumatic impact of an induced abortion.

10. There are numerous studies affirming associations between abortion and both depression and substance abuse (reviewed below and in Tables 2 and 3, Exhibit B). Substance abuse, which constitutes a dysfunctional coping response, and depression have been long established as primary risk factors in the etiology of suicidal ideation and behavior (Gliatto & Rai, 1999). As indicated in the tables, the studies meet the scientific criteria for establishing abortion as a substantial, contributing factor in the etiology of substance use and depression (time sequence,

co-variation, control, and magnitude of effect). Therefore, abortion is both directly and indirectly associated with suicidal ideation and suicide.

Mental Health Problems

11 Abortion is a significant contributing factor in mental health problems. A minimum of 20-30% of women who have had an abortion suffer from serious negative psychological complications (Adler et al., 1990; Bradshaw & Slade, 2003; Coleman, 2005; Coleman et al., 2005; Lewis, 1997; Major & Cozzarelli, 1992; Zolese & Blacker, 1992). With more than 1.3 million abortions performed annually in the U.S., using the conservative 20% figure would yield over 260,000 new cases of mental health problems each year.

12. The results of the four largest, record-based studies published to date have uniformly revealed that abortion increases the risk of serious mental health problems. In Denmark, David et al. (1981) found the overall rate of admission for psychiatric hospitalization was 18.4 and 12.0 per 10,000 for women who had aborted and delivered respectively. For those who were divorced, separated, or widowed, the psychiatric admission rate was 63.8 per 10,000 for women who aborted versus 16.9 for those who delivered. The outcome variable employed was admission to a psychiatric hospital for a psychotic episode, a worst case mental health outcome.

13. In Canada, Ostbye, et al. (2001) compared 41,089 women with an abortion history to a matched group of 39,220 women without a history of abortion, relative to hospitalization for psychiatric problems, with the results revealing a 165% higher rate of hospitalization for the abortion group.

14. The remaining two studies were conducted in the U.S. using data from over 54,000 low-income women on state medical assistance in California. Women who had an abortion in 1989 with possible subsequent pregnancies had significantly higher rates of outpatient psychiatric diagnoses than women with only birth experience in the target year and no history of subsequent abortions after eliminating all cases with psychiatric claims 12-18 months prior to the initial pregnancy (Coleman et al., 2002). This difference was apparent when data for the full time period were examined (17% higher) and when only data from women with claims filed on their behalf within 90 days (63% higher), 180 days (42% higher), 1 year (30% higher), and 2 years (16% higher) of the pregnancy event were considered. Across the 4 year study period, the abortion group had 40% more claims for depression compared to women who delivered. Data using the same sample and focusing on inpatient claims revealed similar findings (Reardon et al., 2003); this is the fourth study.

Psychological Problems

15. In addition to these four studies, numerous additional research reports have been published throughout the world indicating that abortion is a substantial contributing factor to decrements in women's mental health.

16. Abortion is a significant contributing factor in specific psychological problems. The literature pertaining to adverse psychological effects of abortion has grown tremendously in the last two decades, rendering it beyond the scope of this Affidavit to describe in detail all the available evidence demonstrating that abortion is a significant contributing factor to negative psychopathologies. Therefore, in Tables 3 and 4 of Exhibit B, I have provided synopses of the published literature pertaining to depression and anxiety. Application of the criteria for assessing associations between variables definitively demonstrates that within a reasonable degree of scientific probability abortion is a significant contributing factor in depression and anxiety. The analysis of published research offered in this Affidavit further shows that within a reasonable degree of scientific probability abortion is a primary cause in many women's anguish and prolonged mental health struggles.

17. I will highlight the results of one particularly informative prospective study published in January 2006 by New Zealand researchers Fergusson, Horwood and Ridder. Results of the Canterbury Health

and Development Study published in the *Journal of Child Psychology and Psychiatry and Allied Disciplines* revealed that young women who aborted were at a significantly higher risk for depression, anxiety, suicidal behaviors, and substance use disorders compared to both women who carried a pregnancy to term and those who were never pregnant.

18. The study was led by pro-choice researcher, David Fergusson of the Christchurch School of Medicine & Health Sciences who did not expect to find adverse psychological consequences associated with abortion. This study of 1,265 children born in Christchurch in 1977 has a number of positive methodological advantages over other studies: (a) it is prospective, following women over many years; (b) it used comprehensive mental health assessments employing standardized diagnostic criteria of DSM III-R disorders; (c) it reported considerably lower estimated abortion concealment rates compared to previously published studies; (d) the sample represented between 80 – 83% of the original cohort of 630 females; and (e) the study used extensive controls.

19. While 42% of the women who aborted reported major depression by age 25, 39% of post-abortive women suffered from anxiety disorders. In addition, 27% reported experiencing suicidal ideation, 6.8% indicated alcohol dependence, and 12.2% were abusing drugs. Compared to the pregnant/no abortion group, the abortion group scored significantly higher on all these variables except anxiety. Compared to the

never pregnant group, the abortion group scored significantly higher on all variables.

20. Dr. Fergusson and his colleagues challenged the American Psychological Association's recent assertion that "well-designed studies of psychological responses following abortion have consistently shown that risk of psychological harm is low." Dr. Fergusson noted that this claim was based on a small number of studies that suffer from significant methodological problems as well as a general disregard for studies showing negative effects.

21. Ten months after Fergusson's study was published, a prestigious group of psychiatrists and obstetricians wrote a letter to the *London Times* citing the Fergusson study and advocating for more accurate pre-abortion information dissemination: "Since women having abortions can no longer be said to have a low risk of suffering from psychiatric conditions such as depression, doctors have a duty to advise about long-term adverse psychological consequences f abortion."

Increased Risk for Negative Post-Abortion Outcomes

22. There is a vast literature describing women at-risk for negative abortion experiences. Among the most commonly reported risk factors for poor adjustment are difficulty with the decision, emotional investment in the pregnancy, timing during adolescence or being unmarried, involvement in unstable or

violent relationships, conservative views of abortion and/or religious affiliation, second trimester abortions, and feelings of being forced into abortion by one's partner, others, or by life circumstances (Allanson, & Astbury, 2001; Bracken, 1978; Bracken et al., 1974; Campbell et al., 1988; Cozzarelli et al., 1994; Kero et al., 2004; Lewis, 1997; Lyndon et al., 1996; Osofsky & Osofsky, 1972; Osofsky et al., 1973; Remennick & Segal, 2001; Russo & Denious, 2001). Internalized beliefs regarding the humanity of the fetus, moral, religious, and ethical objections to abortion, and feelings of bereavement/loss also frequently distinguish those who suffer profoundly (see Coleman et al., 2005 for a review).

23. The percentage of women falling into "high-risk" groups is in actuality quite high. For example, Husfeldt and colleagues (1995) reported that 44% of the women surveyed had doubts about their decision upon confirmation of pregnancy and 30% continued to express doubts when the abortion date arrived.

24. If a woman has doubts about her abortion and believes it was morally wrong, guilt feelings, which are often implicated in depression are likely to arise. Guilt associated with abortion has been consistently reported (Broen et al., 2004) and identified in the pre-abortion counseling literature (Baker et al., 1999). Rue and colleagues' (2004) study revealed that 78% of U.S. women felt guilt in association with a past abortion. Further, close to 50% of Russian women who reside in a culture that is very accepting of abortion reported guilt feelings.

25. Kero et al. (2001) found that 46% of women who aborted indicated that their thoughts regarding termination evoked a conflict of conscience. The source of such conflict is likely women's understandings of the humanity of the fetus. In Conklin and O'Connor's (1995) study of 800 women who had an induced abortion, those who reported perceiving the fetus as human experienced significantly more post-abortion negative affect and decision dissatisfaction than women who did not. Awareness of the humanity of the fetus is common among women who are seriously contemplating an induced abortion. For example, using semi-structured interviews Smetana and Adler (1979) found that 25% of women confronting an induced abortion decision understood that the fetus was a human being and understood induced abortion as terminating his or her life. In a recent study conducted by Rue et al. (2004), 50.7% of American women and 50.5% of Russian women who had an induced abortion felt induced abortion was morally wrong.

26. The decision to abort is obviously often conflict-ridden with many women seriously questioning their decision and suffering from their choice to abort. Coleman and Nelson (1998) noted that 38.7% of female college students voiced regret in the first few years following an abortion. Moreover, the results of a study by Soderberg and colleagues (1998) indicated that 76.1% of women who had a past abortion would never consider repeating the experience.

Pre-Abortion Counseling

27. The importance of pre-abortion counseling and informed consent for women considering abortion has been well-documented in the scientific literature. The overwhelming preponderance of objective scientific evidence published in prestigious academic journals world-wide indicates that abortion does indeed pose serious mental health risks and significantly increases a woman's chance of dying, particularly by her own hand. These facts were known by the end of 2000 and earlier, and have been strongly reaffirmed with studies since that time.

28. Rosa Acuna had the right to be informed of these risks, as do all women who seek an abortion. Affirmative statements that minimize the risks of mental health problems are incorrect and should never be made when the scientific/medical evidence is to the contrary.

29. Criticism leveled against pre-abortion counseling has focused on insufficient assistance with the decision-process (Butlet, 1996; Stites, 1982). Professionals will more effectively serve women by helping them to avert a decision that can cause later suffering through dissemination of accurate and objective scientific information regarding the risk factors for emotional problems, listening sensitively for any feelings of ambiguity, and offering assistance that facilitates the woman's autonomous decision-making. This idea was emphasized by Miller (1992, p. 91) who stated that "a woman considering abortion who

expresses enjoyment in being pregnant or the desire to have a child to take care of deserves some pre-abortion, exploratory counseling regarding these feelings." A related opinion was expressed by, Lemkau (1991, p. 100) who noted "in a political environment in which a woman's right to choose abortion is constantly challenged, it is easy to forget the importance of the right to choose not to abort."

30. Furthermore, professionals working with women contemplating an abortion need to be encouraged not to interject their own opinions regarding what they perceive to be the best decision for an individual and should help instill confidence in women to not yield to pressures from others as they weigh their options.

Informed Consent

31. Unfortunately, many women who make the decision to abort do so without a thorough understanding of the procedure. Research suggests that feeling misinformed or being denied relevant information often precipitates post-abortion difficulties (Congleton & Calhoun, 1993; Franz & Reardon, 1992).

32. Provision of accurate information pertaining to fetal development would help to insure that women are making decisions that are consistent with their beliefs and value systems. Avoiding discussion of fetal development or using terms like "tissue," "blood," "content of the uterus," or "a clump of cells" to refer to an embryo or fetus may seem to make the women's

decision easier, but it can often encourage a consent that would not have been made if she were told the truth. This deceitful practice is wrong as it denies women the information a reasonably prudent person would expect in considering whether or not to pursue the medical procedure. Moreover, employment of ambiguous, misleading language violates a woman's right to make a fully informed decision and leaves her vulnerable to adverse outcomes, unanticipated at the time of the decision.

33. If a woman obtains subsequent information, contradicting that provided by the abortion facility and used as the basis of her earlier abortion decision, devastating psychological consequences become more probable. This fact is one that has been known in the medical profession for decades. In a 1980 letter published by the *New England Journal of Medicine*, this position is expressed by Riggs: "Women deserve to know exactly what would be removed before they make a decision. The doctor who protects them from the facts to preserve them from anxiety and guilt has made a moral decision on their behalf . . . and to deprive a woman contemplating abortion of a description of the fetus whether or not she requests it, is to deprive her of truly informed consent" (p. 350).

34. In a paper published in the top-rated medical ethics journal, *The Journal of Medical Ethics*, Reardon, Lee, and I found that 95% of a socio-demographically diverse group of women wished to be informed of all possible complications associated with drugs, surgery, and/or other forms of elective treatments, including

abortion (Coleman et al., 2006). In addition, a frequency of complications of 1:100 or higher would factor into most women's elective treatment decisions. As indicated by Gissler and colleagues as a key point in their 2005 article "Elevated mortality risk after a terminated pregnancy has to be recognized in the provision of health care and social services" (p. 462).

35. As previously noted, research firmly indicates that when women feel they have been misinformed regarding the specifics of an abortion procedure, they are more inclined to suffer in the aftermath as they acquire factual information (Congleton & Calhoun, 1993; Franz & Reardon, 1992).

Further Affiant sayeth not."

/s/ Priscilla Coleman
Dr. Priscilla K. Coleman, Ph.D

SWORN TO AND SUBSCRIBED BEFORE ME, the undersigned authority, on this 2nd day of May, 2008.

/s/ Karen Brueggemeier
NOTARY PUBLIC IN AND FOR
THE STATE OF OHIO

My commission expires: 5-29-11
Notary Public, Wood County, Ohio

Exhibit A:
Scientific Literature Relied Upon in Part in the Formation of My Opinions

Adler, N. E., David, H. P., Major, B. N., Roth, S. H., Russo, N. F., & Wyatt, G. E. (1990). Psychological responses after abortion. *Science, 248,* 41-44.

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Exhibit B
Tables 1-4

Table 1: Scientific Studies Identifying Abortion as a Risk Factor in Suicidal Ideation and Suicide.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry*, 47, 16-24.	√	√	√ Those who delivered and were never pregnant used as comparison groups. Statistical control for maternal education childhood sexual abuse, physical abuse Child neuroticism Self-esteem Grade point average Child smoking Prior history of depression, anxiety Prior history of suicide ideation Living with parents Living with partner	√ 27% of women who aborted reported experiencing suicidal ideation This effect was significant at the >.001 level, meaning there was on a 1 in 1000 chance that the result was due to chance. The risk was 4 times greater for women who aborted compared to never pregnant women and more than 3 times greater than women who for women who delivered
2. Gilchrist, A. C. et al (1995). Termination of pregnancy and psychiatric morbidity. *British Journal of Psychiatry* 167:243-	√	√	√ Comparisons included women who were refused abortion and women who chose abortion but changed their minds	√ Among women with no history of psychiatric illness, the rate of deliberate self-harm was significantly higher (70%) after abortion than childbirth
3. Gissler, M., et al. (1996). Suicides after pregnancy in Finland, 1987-94: Register linkage study. *British Medical Journal*, 313, 1431-4	√	√	√ Compared women who aborted to those who delivered, miscarried, and the general population	√ Suicide rate was nearly 6 times greater among women who aborted compared to women who gave birth
4. Gissler, M., et al. (2005). Injury deaths, suicides and homicides associated with pregnancy, Finland 1987-2000. *European Journal of Public Health*, 15, 459-463.	√	√	√ Compared women who aborted to those who delivered, miscarried, and were not pregnant. Distinguished the level of risk associated with suicide and other forms of death.	√ Abortion was associated with a 6 times higher risk for suicide compared to birth.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
5. Reardon, D. C., et al. (2002). Deaths associated with delivery and abortion among California Medicaid patients: A record linkage study. *Southern Medical Journal*, 95, 834-841	√	√	√ Use of homogenous population. Controlled for prior psychiatric history, age, and months of eligibility for state medical coverage	√ Suicide risk was 154% higher among women who aborted compared to those who delivered
6. Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Medical Science Monitor* 10, SR 5-16.	√	√	√ Controlled for severe stress symptoms prior to the abortion, other stressors pre-and post-abortion, several demographic variables, and psycho-social variables (harsh discipline, sexual, physical, and emotional abuse, parental divorce, etc).	√ 36.4% of the American women and 2.8% of the Russian women respectively reported suicidal ideation.

Table 2: Scientific Studies Identifying Abortion as a Risk Factor in Substance Use/Abuse

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Amaro H., Zuckerman B, & Cabral H. (1989). Drug use among adolescent mothers: profile of risk. *Pediatrics, 84,* 144-151.	√	√	√ Other forms of perinatal loss as comparison groups	√ Adolescent drug users when compared to nonusers were significantly more likely to report a history of elective abortion (33% vs. 16.3%). No associations were identified between drug use and parity or other forms of perinatal loss (miscarriage /stillbirth).
2. Coleman, P. K. (2006). Resolution of Unwanted Pregnancy During Adolescence Through Abortion versus Childbirth: Individual and Family Predictors and Consequences. *Journal of Youth and Adolescence.*	√	√	√ Demographic, educational, psychological, and family variables found to predict the choice to abort Exclusive focus on unwanted pregnancies	√ After implementing controls, adolescents with an abortion history, when compared to adolescents who had give birth were 6 times more likely to use marijuana.
3. Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). History of induced abortion in relation to substance use during subsequent pregnancies carried to term. *American Journal of Obstetrics and Gynecology, 187,* 1673-1678.	√	√	√ Results were stratified by potentially confounding factors (marital status, income, ethnicity, and time elapsed since a prior abortion or birth)	√ Compared with women who had previously given birth, women who aborted were significantly more likely to use marijuana (929%), various elicit drugs (460%), and alcohol (122%) during their next pregnancy. Differences relative to marijuana and use of any elicit drug were more pronounced among married and higher income women and when more time had elapsed since the prior pregnancy. Differences relative to alcohol use were most pronounced among the white women and when more time had elapsed since the prior pregnancy.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
4. Coleman, P. K., Reardon, D. C., & Cougle, J. (2005) Substance use among pregnant women in the context of previous reproductive loss and desire for current pregnancy. *British Journal of Health Psychology, 10, 255-268.*	√	√	√ Other forms of loss Age Marital status Trimester in which prenatal care was sought Education Number in household	√ No differences were observed in the risk of using any of the substances measured during pregnancy relative to a prior history of miscarriage or stillbirth. A prior history of abortion was associated with a significantly higher risk of using marijuana (201%), cocaine-crack (198%), cocaine-other than crack (406%), any illicit drugs (180%), and cigarettes (100%).
5. Reardon, D. C., Coleman, P. K., & Cougle, J. (2004) Substance use associated with prior history of abortion and unintended birth: A national cross sectional cohort study. *Am. Journal of Drug and Alcohol Abuse, 26, 369-383.*	√	√	√ Age Ethnicity Marital status Income Education Pre-pregnancy self-esteem and locus of control	√ Compared to women who carried an unintended first pregnancy to term, those who aborted were 100% more likely to report use of marijuana in the past 30 days and 149% more likely to use cocaine in the past 30 days (only approached significance). Women with a history of abortion also engaged in more frequent drinking than those who carried an unintended pregnancy to term. Except for less frequent drinking, the unintended delivery group was not significantly different from the no pregnancy group
6. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47,* 16-24.	√	√	√ Maternal education Childhood sexual abuse, physical abuse Child neuroticism Self-esteem Grade point average Child smoking Prior history of depression, anxiety Prior history of suicide ideation Living with parents Living with partner	√ 6.8% indicated alcohol dependence, and 12.2% were abusing drugs. By age 25.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
7. Hope, T. L., Wilder, E. I., & Watt, T. T. (2003). The relationships among adolescent pregnancy, pregnancy resolution, and juvenile delinquency, *The Sociological Quarterly, 44,* 555-576.	√	√	√ Controls for a wide range of socioeconomic and demographic variables likely to influence juvenile delinquency.	√ Compared to adolescents who ended their pregnancies through abortion, those who keep their babies experienced a dramatic reduction in smoking and marijuana use
8. Reardon D.C., Ney, P.G. (2002) Abortion and subsequent substance abuse. *American Journal of Drug and Alcohol Abuse, 26,* 61-75.	√	√	√ Controlled for substance use prior to the abortion and age	√ Women who aborted a first pregnancy were 5 times more likely to report subsequent substance abuse than women who carried to term. Women who aborted a first pregnancy were 4 times more likely to report substance abuse compared to those who suffered from a non-voluntary pregnancy loss
9. Yamaguchi D, & Kandel D. (1987). Drug use and other determinants of premarital pregnancy and its outcome: A dynamic analysis of competing life events. *Journal of Marriage and the Family, 49,* 257-270.	√	√		√ The use of illicit drugs other than marijuana was 6.1 times higher among women with a history of abortion when compared to women without a history.

Table 3: Scientific Studies Identifying Abortion as a Risk Factor in Depression.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Bradley, C.F. (1984) Abortion and subsequent pregnancy. *Canadian Journal of Psychiatry, 29*, 494.	√	√	√ Women with and without a history of abortion had similar demographic characteristics, obstetric experiences, and attitudes about labor and birth.	√ Women, who aborted, when compared to women without a history of abortion, were significantly more likely to report depressive affect during pregnancy and in the postpartum period.
2. Coleman, P.K.,& Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. *Journal of Social and Clinical Psychology, 17*, 425-442.	√	√	√ Compared men and women with abortion experience. Time elapsed since abortion	√ Depression increased after abortion: female: 56.7%; male: 25.9%
3. Coleman, P. K., Reardon, D. C., Rue, V., & Cougle, J. (2002). State-funded abortions vs. deliveries: A comparison of outpatient mental health claims over four years. *American Journal of Orthopsychiatry, 72*, 141-152	√	√	√ Comparison groups likely very similar except for the abortion experience Controls for pre-pregnancy psycho-logical difficulties, age, and months of eligibility	√ Across the 4-yrs, the abortion group had 40% more claims for neurotic depression than the birth group
4. Congleton, G. & Calhoun, L. (1993). Post-abortion perceptions: A comparison of self-identified distressed and non-distressed populations. *International Journal of Social Psychiatry, 39*, 255-265	√	√	√ Compared women who self-identified as distressed and non-distressed only.	√ Depression reported in 20% of women who aborted.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
5. Cougle, J., Reardon, D. C., & Coleman, P. K. (2003). Depression associated with abortion and childbirth: A long-term analysis of the NLSY cohort. *Medical Science Monitor, 9,* CR105-112	√	√	√ Controlled for prior psychological state and several other variables: age, race, marital status, divorce history, education, and income (stratification by ethnicity, current marital status, and history of divorce)	√ Women whose 1st pregnancies ended in abortion were 65% more likely to score in the "high-risk" range for clinical depression. Differences between the abortion and birth groups were greatest among the demographic groups least likely to conceal an abortion (White: 79% higher risk; married: 116% higher risk; 1st marriage didn't end in divorce: 119% higher risk).
6. Cozzarelli, C. (1993). Personality and self-efficacy as predictors of coping with abortion. *Journal of Personality and Social Psychology, 65,* 1224-1236.	√	√		√ 3 weeks after the abortion, depression was higher than general population norms, but lower than psychiatric norms.
7. Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. *Journal of Obstetrics and Gynecology, 5,* 504-509.	√	√	√ Used a matched control group	√ Previous abortion was significantly associated with depression among the pregnant women
8. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47,* 16-24.	√	√	√ Maternal education Childhood sexual abuse, physical abuse Child neuroticism Self-esteem Grade point average Child smoking Prior history of depression, anxiety Prior history of suicide ideation Living with parents Living with partner	√ 42% of the women who had aborted reported major depression by age 25.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
9. Harlow, B. L., Cohen, L. S., Otto, M. W., Spiegelman, D., & Cramer, D. W. (2004). Early life menstrual characteristics and pregnancy experiences among women with and without major depression: the Harvard Study of Mood and Cycles. *Journal of Affective Disorders, 79,* 167176.	√	√	√ Employed demographic controls (age, age at menarche, educational attainment, and history of marital disruption	√ Compared to women with no history of induced abortion, those with two or more were 2-3 times more likely to have a lifetime history of major depression at study enrollment. When only antecedent induced abortions were compared to no history of abortion, there was a three fold increase risk of developing depression later in life.
10. Major, B., Cozzarelli, C., Cooper, M.L., Zubek, J., Richards C., Wilhite, M., & Gramzow, R.H. (2000).Psych-ological responses of women after first trimester abortion. *Archives of General Psychiatry, 57,* 777-84.	√	√	√ Controls for demographic characteristics, medical complications, and prior mental health	√ Two years post-abortion, 28% were not satisfied with their decision, 31% would not have the abortion again, and 20 % were depressed. Younger age and having more children pre-abortion predicted more negative post-abortion outcomes.
11. Major, B. Cozzarelli, C., Sciacchitano, A. M., Cooper, M. L., Testa, M., & Mueller, P. M. (1990). Perceived social support, self-efficacy, and adjustment to abortion. *Journal of Personality and Social Psychology, 59,* 186-197.	√	√		√ Immediately after abortion Mild depression 21% Moderate depression 11% Severe depression 4%

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
12. Miller, W. B., Pasta, D. J., & Dean, C. L. (1998). Testing a model of the psychological consequences of abortion. In L. J. Beckman and S. M. Harvey (eds)., The new civil war: The psychology, culture, and politics of abortion. Washington, DC: American Psychological Association.	√	√	√	√ 2 weeks post-abortion: 29.5% felt some guilt, 36.6% experienced some depression, 30.4% reported mood problems, 17.3% reported decreased relationship satisfaction, and 26.9% reported decreased interest in sex. 6-8 weeks post-abortion: 35.9% felt some guilt, 35.9% experienced some depression, 30% reported mood problems, 22% reported decreased relationship satisfaction, and 26% reported decreased interest in sex.
13. Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? *Journal of Adolescent Health, 29*, 2-11.	√	√	√ Compared current sample results with those reported in other studies using similar samples..	√ 19% experienced moderate to severe levels of depression 4 weeks post-abortion.
14. Reardon, D. C., & Cougle, J. (2002) Depression and Unintended Pregnancy in the National Longitudinal Survey of Youth: A cohort Study. British *Medical Journal, 324,* 151-152.	√	√	√ Confined analyses to unintended pregnancy aborted or delivered. Controls for the following: prior psychiatric state, family income. Education, race, age at first pregnancy Stratified by marital status	√ The percentage of women who carried to term considered to be in the high-risk range for depression was 22.7% compared to 27.3% of women who aborted (OR=1.54) Among married women, the percentage of women who carried to term considered to be in the high-risk range for depression was 17.3% compared to 26.2% of women who aborted (OR=2.38)

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
15. Reardon, D. C., Cougle, J., Rue, V. M., Shuping, M., Coleman, P. K., & Ney, P. G. (2003). Psychiatric admissions of low-income women following abortion and childbirth. *Canadian Medical Association Journal,* 168, 1253-1256.	√	√	√ Comparison groups are likely very similar except for the abortion experience. Controls for pre-pregnancy psych-ological difficulties, age, and months of eligibility Extended time frame	√ Across the 4-yrs, the abortion group more claims for depressive disorders compared to the birth group, with the percentages equaling 90%, 110%, and 200% for depressive psychosis, single and recurrent episode, and bipolar disorder respectively.
16. Schmiege, S., & Russo, N. F. (2005). Depression and unwanted first pregnancy: Longitudinal cohort study. *British Medical Journal*	√	√	√ Age Age at first pregnancy 1992 marital status Education Family income	√ Percent of women exceeding the depression cut-off score on the Center for Epidemiological Studies depression scale after an abortion: Married White women: 16% Married Black women: 24% Unmarried White women: 30% Unmarried Black women: 38% Non-Catholic: 27% Catholic: 20%
17. Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. *British Journal of Obstetrics and Gynecology, 105,* 1288-1295.	√	√		√ 1 month post-abortion: Cases of depression: 9%

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
18. Söderberg H, Janzon L and Sjöberg NO (1998). Emotional distress following induced abortion. A study of its incidence and determinants among abortees in Malmö, Sweden. European *Journal of Obstetrics and Gynecology and Reproductive Biology 79*, 173-8	√	√	√ Utilized a case control data analysis strategy	√ 50-60% of the women experienced emotional distress of some form (e.g., mild depression, remorse or guilt feelings, a tendency to cry without cause, discomfort upon meeting children), classified as severe in 30% of cases. 76.1% said that they would not consider abortion again (suggesting indirectly that it was not a very positive experience).
19. Suri, R, Altshuler, L., Hendrick, V. et al. (2004). The impact of depression and fluoxetine treatment on obstetrical outcome. *Archives of Women's Mental Health, 7,* 193-200.	√	√		√ 46 women with a history of depression had a significantly higher mean number of prior therapeutic abortions than 16 women without a history of depression (.78 vs. .31). The mean number of prior pregnancies and spontaneous abortions did not differ.
20. Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. *British Journal of Obstetrics and Gynecology, 98,* 396-399.	√	√		√ Clinically significant feelings of depression at 1 month post-abortion by 10% of the sample.

Table 4: Scientific Studies Identifying Abortion as a Risk Factor in Anxiety Disorders.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
1. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2004). Psychological impact on women of miscarriage versus induced abortion: A 2 year follow-up study. *Psychosomatic Medicine, 66,* 265-271.	√	√	√ Number of children Marital status Vocational status	√ 10 days after the pregnancy ended, 30% of those who had an abortion scored high on measures of avoidance or intrusion, which includes symptoms such as flashbacks and bad dreams. 2 years after the pregnancy ended, nearly 17% of 80 women who had an abortion scored highly on a scale measuring avoidance symptoms, compared with about 3% of those who miscarried.
2. Broen, A.N., Moum, T., Bodtker, A. S., & Ekeberg, O. (2005). Reasons for induced abortion and their relation to women's emotional distress: a prospective, two-year follow-up study. *General Hospital Psychiatry, 27,* 36-43.	√	√	√ Marital status Psychiatric history	√ Male pressure on women to abort was significantly associated with negative abortion-related emotions in the two years following an abortion. Pre-abortion psychiatric history was not significantly related to immediate negative abortion related emotion or with negative emotional responses measured at 2 years out. 23.8% of the sample scored high on The Impact of Events Scale (a measure of stress reactions after a traumatic event) 10 days after the abortion, 13.3% at 6 months, and 1.4% after 2 years

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
3. Coleman, P.K.,& Nelson, E.S. (1998). The quality of abortion decisions and college students' reports of post-abortion emotional sequelae and abortion attitudes. *Journal of Social and Clinical Psychology, 17,* 425-442.	√	√	√ Gender: Compared men and women with abortion experience. Time elapsed since abortion	√ Anxiety increased after the abortion: female: 13.3%; male: 9.7%
4. Cougle, J., Reardon, D. C., Coleman, P. K., & Rue, V. M. (2005).General-ized anxiety associated with unintended pregnancy: A cohort study of the 1995 National Survey of Family Growth. *Journal of Anxiety Disorders, 19, 137-142*	√	√	√ All women were experiencing an unintended pregnancy Stratification by ethnicity, current marital status, and age.	√ The odds of experiencing subsequent Generalized Anxiety was 34% higher among women who aborted compared to delivered. Greatest differences among the following demographic groups: Hispanic: 86% higher risk, Unmarried at time of pregnancy: 42% higher risk; under age 20: 46% higher risk.
5. Fayote, F.O., Adeyemi, A.B., Oladimeji, B.Y. (2004). Emotional distress and its correlates. *Journal of Obstetrics and Gynecology, 5,* 504-509.	√	√	√ Used a matched control group	√ Previous abortion was significantly associated with anxiety among the pregnant women
6. Fergusson, D. M., Horwood, J., & Ridder, E. M. (2006). Abortion in young women and subsequent mental health. *Journal of Child Psychology and Psychiatry, 47,* 16-24.	√	√	√ Maternal education Childhood sexual abuse, physical abuse Child neuroticism Self-esteem Grade point average Child smoking Prior history of depression, anxiety Prior history of suicide ideation Living with parents Living with partner	√ 39% of post-abortive women suffered from anxiety disorders by age 25.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
7. Lauzon, P., Roger-Achim, D., Achim, A., & Boyer, R. (2000). Emotional distress among couples. involved in first trimester abortions. *Canadian Family Physician, 46,* 2033-2040.	√	√	√ Random sample of the general population of reproductive age used a s the control group	√ Before the abortion, 56.9% of women and 39.6% of men were much more distressed than their respective controls. Three weeks after the abortion, 41.7% of women and 30.9% of men were still highly distressed.
8. Major, B.,& Gramzow, R. H. (1999).Abortion As stigma: Cognitive and emotional implications of concealment. *Journal of Personality and Social Psychology ,77, 735-745*	√	√	.	√ Two years after abortion: Intrusive thoughts - quite a bit: 3% - some intrusive thoughts: 62%
9. Sivuha, S. Predictors of Posttraumatic Stress Disorder Following Abortion in a Former Soviet Union Country. *Journal of Prenatal & Perinatal Psych & Health,17,* 41-61 (2002).		√	.	√ 35% of women had some posttraumatic consequences of abortion (elevated avoidance, intrusion, or hyper-arousal scores) 46% of women had evidence of PTSD, exceeding the cut-offs for both intrusion and avoidance subscales 22% of women experienced PTSD, exceeding the cut-offs on all 3 subscales
10. Pope, L. M., Adler, N. E., & Tschann, J. M. (2001). Post-abortion psychological adjustment: Are minors at increased risk? *Journal of Adolescent Health, 29,* 2-11.	√	√	√ Compared current sample results with those reported in other studies using similar samples.	√ Impact of Events Scale – Intrusion Subscale (a measure of stress associated with a traumatic event) score = 13.46, which is similar to adults experiencing a recent parental bereavement.

Study	Time sequence	Co-variation	Control	Results/Magnitude of effect
11. Rue, V. M., Coleman, P. K., Rue, J. J., & Reardon, D. C. (2004). Induced abortion and traumatic stress: A preliminary comparison of American and Russian women. *Medical Science Monitor* 10, SR 5-16.	√	√	√ Extensive controls for background variables: - Severe stress symptoms prior to the abortion - Other stressors pre- and post-abortion - Several demographic variables - Psycho-social variables (harsh discipline, abuse, parental divorce, etc).	√ The percentages of Russian and U.S. women who experienced 2 or more symptoms of arousal, 1 or more symptom of re-experiencing the trauma, and 1 or more experience of avoidance (consistent with DSM-IV diagnostic criteria for PTSD) were equal to 13.1% and 65% respectively.
12. Slade, P., Heke, S., Fletcher, J., & Stewart, P. (1998). A comparison of medical and surgical methods of termination of pregnancy: Choice, psychological consequences, and satisfaction with care. *British Journal of Obstetrics and Gynecology, 105,* 1288-1295.	√	√		√ 1 month post-abortion: Cases of anxiety: 27%
13. Williams, G. B. (2001). Short-term grief after an elective abortion. *Journal of Obstetrics, Gynecologic, and Neonatal Nursing, 30,* 174-183.	√	√	√ Controlled for other forms of loss and psychiatric history Used a control group of women who had not aborted	√ Women with a history of elective abortion experienced more grief in terms of loss of control, death anxiety, and dependency than controls.
14. Urquhart D.R., & Templeton, A. A. (1991). Psychiatric morbidity and acceptability following medical and surgical methods of induced abortion. *British Journal of Obstetrics and Gynecology, 98,* 396-399.	√	√		√ Clinically significant feelings of anxiety at 1 month post-abortion by 10% of the sample.